Health Navigation:
local integration to maximize resources

Dallas County Public Health

November 2013

2008 – The Issue

- Agencies, clinics, community resources isolated; minimal connection/communication
- Program eligibility, benefits and application process confusing & ever changing
- No single person/entity knew the entire landscape of community resources/services

“ *. . . patchwork of programs/resources with no central point of information or coordination*”

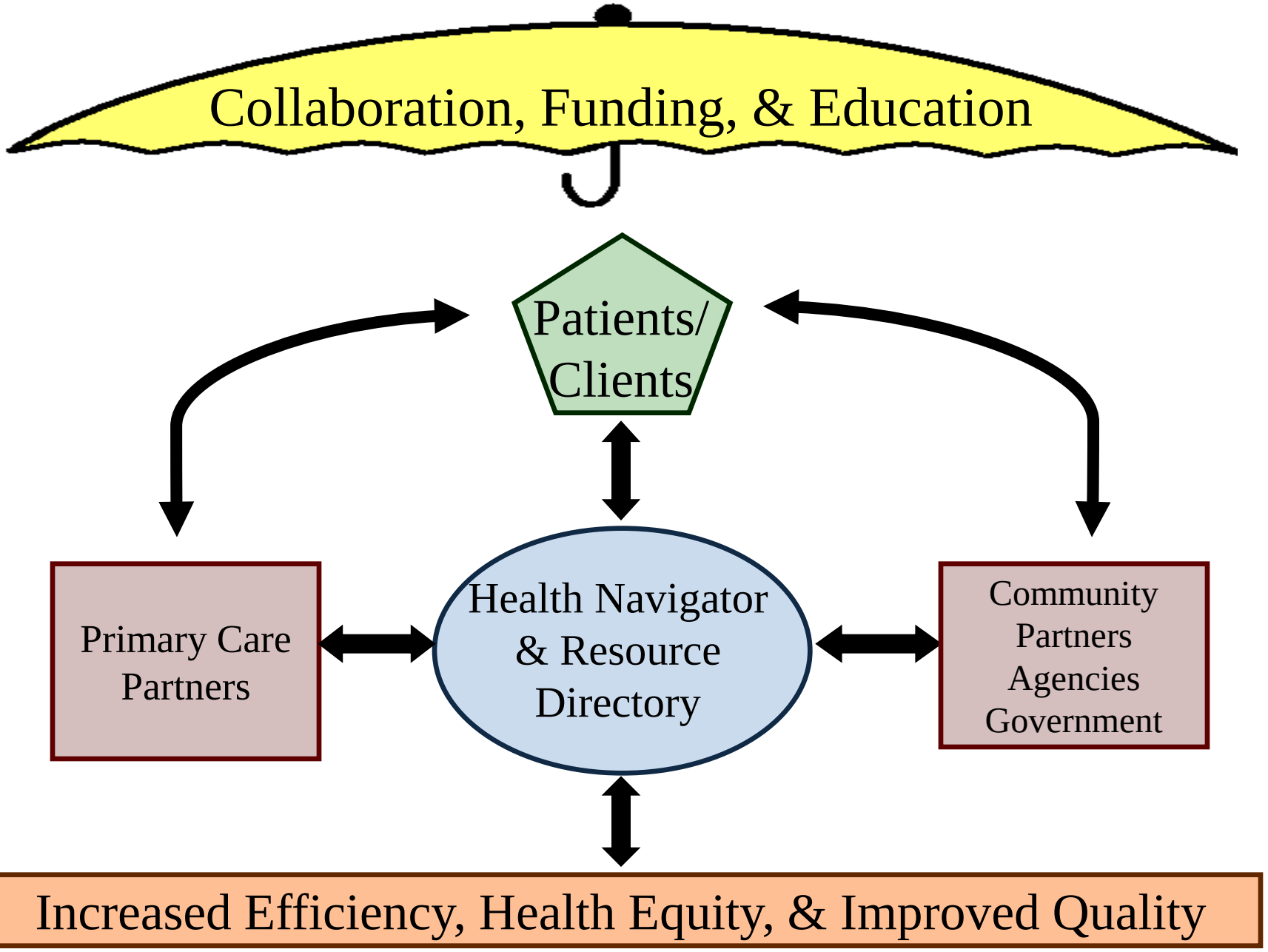
Resulting Situation

- Social determinants/issues not recognized in connection to overall health; not addressed
- Residents seeking assistance make multiple calls to various entities; many become frustrated and give up
- Agencies/programs receive numerous, time consuming inquiries; overworked staff does not have time and/or knowledge to adequately address all issues/concerns

2009 – The Vision

Dallas County Partnership for Health determined the need for an online Resource Directory and a Health Navigator.

"***Residents of Dallas County will have access to available resources in the county through one point of contact, with emphasis on timely referrals, fewer steps to receipt of care, efficiency, increased options and improved outcomes.***"


Collaboration, Funding, & Education
Patients/ Clients
Primary Care Partners
Health Navigator & Resource Directory
Community Partners Agencies Government
Increased Efficiency, Health Equity, & Improved Quality

How it Works

- Healthcare provider, agency or individual may refer to health navigation (healthcare providers are given priority)
- Providers complete a SHORT form and fax referral
- Navigator
  - Contacts client within 3 days
  - Screens for additional information/needs
  - Refers/assists client in obtaining resources
  - If referred by a healthcare provider, follows up with client on progress and completes information loop back to provider

Health Navigation Role:

- Hands on assistance: applications, paperwork, translation/interpretation
- Flexibility in mode and location of contact
- Information, choice and support for client to make decisions regarding needs/programs/services
- Access to a medical payment source/access to medication
- Access to other “social/non-medical” services (housing, heat assistance, childcare, food, mental health/substance abuse, etc.)

Health Navigation is Not:

- Emergency Service
- Primary Care Provider
- Case Manager/Care Coordinator/Health Coach
- Discharge Planner

Health Navigation does assist all of these roles.

Health Navigation is a shared community utility that helps integrate existing community resources.

Maria's Story – Health Navigation in Action

Health Navigation Benefits

To Patients, Providers & Community:

- Access to payment source/meds
- Help address social determinants
- Can impact ER visits, hospital admissions & readmissions
- Integrates & maximizes community resources

Lessons Learned #1
Range of Skills & Knowledge Needed

- Local, State, Federal Resources
- Children/Families
- DHS/Medicaid
- Aging/Medicare
- Bilingual
- Health/Medical

Utilize a team approach – Registered Nurse, Social Worker, Community Health Worker

Lessons Learned #2
Need/Utilization by Providers

- Initially fewer referrals than expected
- Providers trained to focus on clinical status; not underlying issues/causes or quality of life
- Discomfort with “non-medical” issues
- *4 in 5 Surveyed Physicians:*
  - *Say unmet social needs are directly leading to worse health (everyone, not just low-income)*
  - *Are not confident in their capacity to address their patient’s social needs (RWJF Survey; Health Care’s Blind Side December 2011)*

Community Transformation Grant

assisted with TA to reach out to providers

Lessons Learned #3
Data/IT Support

- Web based resource directory
- Health Navigation database
- Workflow (follow-up dates, team coordination, updates to providers)
- Numbers served, demographics
- Show utilization & effectiveness

2012 – 2013 Data

- Averaging 50 clients per month
- Averaging 3.5 Contacts per Client
- Referral Sources
  - 30% Healthcare Providers
  - 30% Community Partners
  - 40% Self/Family
- Primary Presenting Issue
  - 68% Access to Care
- Barriers
  - 50% Income

Contact Information

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Maria's Story
Health Navigation in Action

Maria, a woman in her early 60's, was referred to the Health Navigation program by her healthcare provider because her diabetes was not well controlled and the provider suspected that Maria was not taking her medication regularly due to financial issues. The Health Navigator met with Maria at her home and found that despite working two part-time jobs, Maria was experiencing financial difficulty and emotional stress. Assisted by the Health Navigator, Maria applied for a Prescription Assistance Program and was able to receive her medication at a greatly reduced cost. The Health Navigator also helped Maria apply for the Low Income Heat Assistance Program and the Supplemental Food for Seniors Program. After several weeks, the Health Navigator checked back in with Maria who confessed that even though she was taking her medication regularly now, she was still having trouble sticking to her diabetic diet and exercising. The Health Navigator helped Maria register for Better Choices, Better Health (a chronic disease self management program) and assisted in arranging transportation to the classes via a volunteer program through Maria's church. The Health Navigator reported back to Maria's healthcare provider on actions taken. Several months later, the Health Navigator received a thank you call from Maria's healthcare provider. Maria's diabetes was now well controlled and Maria had lost 4 pounds.